AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY GROUP(S): ALL

The following medical services are provided.

1. Inpatient Hospital Services (Other than services in an institution for Mental Disease)
2.a. Outpatient Hospital Services
2.b. Rural Health Clinic Services
3. Other Laboratory and X-ray Services
4.a. Skilled Nursing Facility Services
4.b. EPSDT services for individuals under age 21
4.c. Family Planning Services and Supplies
5. Physicians' Services - Office, Home, Hospital, Skilled Nursing Facility or Elsewhere
6.a. Podiatrists' Services
6.b. Optometrists' Services
6.c. Chiropractors' Services
7. Home Health Services
9. Clinic Services
10. Dental Services
12.a. Prescribed Drugs
12.b. Dentures
12.c. Prosthetic Devices
12.d. Eyeglasses
14.a. Inpatient Hospital Services for individuals 65 years of age or older in Institutions for Mental Diseases
14.b. Skilled nursing facility services for individuals 65 years of age or older in institutions for mental diseases
14.c. Intermediate care facility services for individuals 65 years of age or older in institutions for mental disease
15.a. Intermediate Care Facility Services (Other than services in an Institution for Mental Disease)
15.b. Including such services in a public institution (or distinct pRT thereof) for the mentally retarded or persons with related conditions
16. Inpatient Psychiatric Hospital Services for individuals under 22 years of age
17. Nurse-midwife services
18. Hospice services
19. Extended services to pregnant women
20. Targeted Case Management Services
21.a. Transportation
21.d. Skilled nursing facility services for individuals under age 21
21.e. Emergency hospital services
21.g. Oxygen and Related Equipment
24. CRNP Services
25. Case Management Services

JAN 12 1994

State/Territory: Pennsylvania

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: /_/No limitations /X/ With limitations*

2.a. Outpatient hospital services.

   Provided: /_/No limitations /X/ With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

   /X/ Provided: /X/ No limitations /_/With limitations*

   /_/ Not provided.

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   /X/ Provided: /X/ No limitations /_/With limitations*

   d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.

   /X/ Provided: /X/ No limitations /_/With limitations*

3. Other laboratory and x-ray services.

   Provided: /_/ No limitations /X/With limitations*

*Description provided on attachment.

SERVICE	LIMITATIONS

1. Inpatient Hospital Services

(a) Payment for blood is limited to the first three pints of whole blood provided during each period of hospitalization. An exception to this limit is made only if the patient has hemophilia, in which case payment is made for the blood or blood products the patient requires.

(b) Payment for inpatient psychiatric services in a general hospital is limited to days certified by the Department, during which the individual with a psychiatric diagnosis is a patient in an approved unit. An exception will be made to this requirement in an emergency situation, in which case payment will be made for a maximum of 2 days of inpatient psychiatric care in an area other than the psychiatric unit.

(c) Payment for inpatient drug/alcohol services in a general hospital is limited to days certified by the Department during which the individual with a drug/alcohol diagnosis is a patient in a drug/alcohol unit approved by the Department of Health. An exception will be made to this requirement in an emergency situation, in which case payment will be made for a maximum of 2 days of inpatient care in an area other than the drug/alcohol unit.

(d) Each recipient is limited to two (2) periods of therapeutic leave per calendar month. Neither of these periods of therapeutic leave may exceed 12 hours in a calendar day.

Exception: Recipients receiving care in an acute care general hospital's extended acute care psychiatric unit approved by the Department are limited to seven 12-hour periods of therapeutic leave per month which may be used consecutively.

(e) The Department determines recipient eligibility for compensable transplant procedures in accordance with written standards which are applied uniformly to similarly situated individuals. Compensable transplant procedures must be certified by a qualified physician as being reasonable and necessary. Any participating qualified physician and any licensed hospital that has a Certificate of Need to perform transplants is eligible to receive payment for the procedure.

SERVICE	LIMITATIONS

1. Inpatient Hospital Services (Continued)

(e) continued

To obtain a Certificate of Need to perform transplants, a facility must meet certain general standards and criteria as cited in Chapter 42(b) of the State Health Plan.

Organ transplant services are available under EPSDT if medically necessary.

Payment will be made for transplants if the Department agrees that the procedure is medically necessary and no alternative common medical treatment as recognized by the medical community is available. The transplant must be utilized for the management of diseases as a recognized standard treatment in the medical community and must not be of an investigational or research nature and must be used for end-stage diseases, not as prophylactic treatment. The Department currently makes payment for kidney, heart, heart/lung, lung (both single and double), liver, pancreas and bone marrow transplants.

General medical indications for specific organ transplants are as follow:

Kidney

End Stage Renal Disease.

Heart

Cardiomyopathy which is end-stage or irreversible where medical management can no longer restore patient to activities of daily living. Homogenic transplants only (no artificial devices or primates).

Heart/Lung

Severe, irreversible, benign lung disease with secondary cardiac failure where lung transplant alone would not restore adequate cardiac function.

SERVICE	LIMITATIONS

1. Inpatient Hospital Services (continued)

(e) continued

Lung

Single - Severe, irreversible, benign lung disease that is severely restricting activities of daily living and no longer amenable to standard medical treatment. Cardiac failure may or may not be present.

Double - Severe, irreversible, benign lung disease that is severely restricting activities of daily living and no longer amenable to standard medical treatment. The significant factor is the presence of a disease that typically includes infection of a chronic nature, for example, Cystic Fibrosis.

Liver

End Stage Liver Disease, non-malignant in etiology.

1. Acute, fulminant liver necrosis/failure such as seen in certain toxic states, for example, acetominophen ingestion in toxic amounts.

2. Chronic liver failure where the complications of encephalopathy for ascites and/or variceal bleeding or other complications are no longer amenable to or controlled by recognized medical management.

Pancreas

Type I Insulin Dependent Diabetes Mellitus (IDDM) secondary to traumatic or surgical removal of the pancreas where alternative medical management is no longer possible in order to permit reasonable activities of daily living. Suitable documentation showing this status must be provided. The presence of associated progressive life threatening complications of Type I IDDM, such as retinopathy and peripheral vascular disease, would effect consideration and would have to be individually evaluated.

SERVICE	LIMITATIONS

1. Impatient Hospital Services
(continued)

(e) continued

Bone Marrow

For the treatment of certain diseases where it has come to represent a standard approach to treatment of the disease such as lymphomas and leukemias. Not approved for the treatment of diseases which the Department considers to still be of an investigative or research nature.

(f) Payment is not made for:

(1) transsexual surgical procedures for gender change or reassignment, e.g., penile construction, revision of labia, vaginoplasty, vaginal dilation, vaginal reconstruction, penectomy, orchiectomy, mammoplasty, mastectomy, hysterectomy or release of vaginal adhesions;

(2) medical or dental services or surgical procedures performed on an inpatient basis which could have been performed in an outpatient department, ambulatory surgical center, short procedure unit or in a practitioner's office, e.g., myringotomy, vasectomy or dental procedures which may be provided in an outpatient setting without undue risk to the patient;

(3) inpatient hospital services provided in conjunction with physicians' services identified as OP (outpatient) procedures in the Medical Assistance fee schedule;

(4) medical or dental services or surgical procedures which could have been performed in an outpatient setting;

(5) acupuncture, unnecessary surgery, insertion of penile prostheses, gastroplastry for morbid obesity, gastric stapling, or ileo-jejunal shunt except when all other types of treatment of morbid obesity have failed and other procedures which may be experimental, are not in accordance with customary standards of medical practice or are not commonly used;

SERVICE	LIMITATIONS

1. Inpatient Hospital Services
(continued)

(f) continued

(6) plastic or cosmetic surgery for beautification purposes. For accidental injury, plastic surgery is compensable if performed for the purpose of improving the functioning of a deformed body member;

SERVICE	LIMITATIONS

1. Inpatient Hospital Services
(continued)

(7) inpatient dental cases involving oral rehabilitation or restorative services, except for procedures performed for treatment of a secondary diagnosis. Exceptions are made due to the nature of the surgery or the condition of the patient if documentation in the patient's medical record justifies the procedure in an inpatient setting.

(8) diagnostic tests and procedures that can be performed on an outpatient basis and diagnostic tests and procedures not related to the diagnoses that require that particular inpatient stay.

(9) sterilizations performed on individuals under 21 years of age;

(10) sterilizations performed on individuals 21 years of age or older who have not met the requirements of the Consent Form for sterilization;

(11) hysterectomies performed solely for the purpose of sterilization;

(12) abortion procedures performed on individuals if a "Physician Certification for an Abortion" form has not been completed:

(13) services and items for which full payment available through Medicare, other financial resources of other health insurance programs;

(14) services and items not ordinarily provided to the general public;

(15) methadone maintenance;

(16) periods of absence from the hospital for a purpose except for therapeutic leaves;

(17) diagnostic or therapeutic procedures solely for experimental, research or education purposes;

SERVICE	LIMITATIONS
1. Inpatient Hospital Services (continued)	(18) unnecessary admissions and conditions which do not require hospital-type care; (19) inpatient services provided to patients who no longer require acute short term inpatient hospital care (inappropriate hospital services). For patients who do require skilled nursing or intermediate care, payment will be made to the hospital only if the patient is in a certified and approved hospital-based skilled nursing or intermediate care unit; (20) inpatient hospital days not certified under the Department's Concurrent Hospital Review Process (CHR) process or, in the event that the hospital is granted an exemption from CHR, not certified by the hospital's in-house utilization review process. (21) days of inpatient care due to unnecessary delay in applying for a court ordered commitment, grace periods, administrative days and custodial care related or unrelated to court commitments or to the Child Protective Services. (22) any inpatient hospital services provided to a recipient by the transferring hospital on or after the effective date of a court commitment to another facility; (23) days of inpatient hospitalization due to the failure to promptly request or perform necessary diagnostic studies, medical-surgical procedures, or consultations; (24) Friday or Saturday admissions unless the admission is a documented emergency or the procedure for which the patient was admitted is performed on the day of, or the day following, admissions; (25) the day of discharge from inpatient hospital care; (26) any day of inpatient hospital care provided to a recipient whose medical condition makes him or her suitable for an alternate level of care or long term psychiatric care.

State: [illegible]
DESCRIPTION OF LIMITATIONS

Service	Limitations
1. Inpatient hospital services and room	1. Services related to treatment infertility.